

Tobacco: One of the big issues

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“...smokers aren’t the problem. Tobacco is the problem. Smokers can be part of the solution even if they can’t quit at this time...[eg].by smoking outside and not in the car” (Paparangi Reid. Public health physician and Maori researcher).

The top four causes of disease burden (combination of mortality and morbidity) in Australia are Ischaemic Heart Disease, stroke, lung cancer and Chronic Obstructive Pulmonary Disease¹. Given that these are all influenced by tobacco, it is not surprising that tobacco is the largest preventable cause of death, disease and disability². Clearly tobacco has to stay high on our list of concerns as health practitioners. The Australian Institute of Health and Welfare (AIHW) estimates that tobacco accounts for 12.1% of all male burden of disease and 6.8% for all the female burden of disease¹. Put another way, a teenager who smokes and does not quit has a one in two chance of dying as a result of smoking³.

The Northern Rivers Area in NSW is implementing a policy for the management of nicotine dependence for all inpatients.

■ Smoke free inpatients

The NSW smoke free health care policy includes guidelines for the management of nicotine dependent inpatients. This is a commendable step in proactive health care, probably also triggered by the occupational health issues for staff exposed to environmental smoke. The essence of it is that:

- All inpatients will be asked about their smoking status prior to admission to identify nicotine dependent patients
- They will be offered “brief intervention” and pharmacotherapy (nicotine replacement therapy (NRT)) for those who need it
- Advice to those interested in continuing cessation on discharge.

A feature is that the above will be undertaken by appropriately trained nurses rather than requiring doctor initiation. This is based on the experience from trial hospitals in NSW where it needed to be nurse initiated and protocol driven to get significant uptake (personal communication, Annie Kia, NRAHS).

A difficulty that comes to mind is that patients will have to get their own supply of NRT quickly after discharge or go “cold turkey”, or smoke. Not everyone leaving hospital will have a spare \$30 for a week’s supply of patches but may more easily be able to procure cigarettes. I don’t see any major ethical problem with this since smokers face this situation day to day. However there is a possibility that some positive aspects of NRT may be diminished by repeated “failed” attempts associated with hospital admissions. On the other hand, familiarisation with NRT may improve acceptability and confidence for future cessation attempts with NRT. There does not appear to be any literature reporting the evaluation of equivalent inpatient policy on overall long-term cessation rates.

A comprehensive literature review of the literature on Indigenous Australians and Tobacco was undertaken by Rowena Ivers as part of her PhD at Menzies School of Health Research in 2001. There is limited evidence specifically from interventions in Indigenous communities. For the most part we have to think about appropriate application of evidence derived from non-Indigenous populations. Differing social norms, personal and health priorities, cultural, language, literacy and financial issues may obviously be important. Current evidence suggests that tobacco interventions at a clinical level in Indigenous community settings are effective but may not be as effective as expected from the non-Indigenous population.

■ GPs and Nicotine Replacement Therapy

The review of evidence undertaken for the National Tobacco Strategy is a valuable collation and distillation of the large body of research about tobacco interventions⁴ and is recommended for anyone wishing to delve into the detail. Spending some time helping our patients to quit is one of the most cost effective interventions we can do as GPs⁴. This is true for very brief advice as well as for longer, more complex counseling. More time spent on advice and support for cessation increases the likelihood of cessation⁵. The addition of NRT approximately doubles the likelihood of cessation over brief or longer advice/counseling alone⁴.

Most smokers expect their doctor to advise them to quit as part of good health care and most smokers want to quit. We should not feel as though we are being inappropriately intrusive when raising the importance of quitting.

■ Nicotine replacement therapy

There are now a number of products for NRT (see Table 1) that are available over the counter, but only subsidised for Department of Veterans' Affairs patients. They can be thought of in two main groups, those to be actively used, intermittently topping up the nicotine levels to prevent withdrawal symptoms, and those passively used in a standard way through the day.

My personal view is that the passive (patches) are going to be easier to use as the patient does not have to remember to do it so many times a day. However some people may prefer a more active role in their quitting program, with the recurrent decision to use NRT gum, inhaler, lozenge or spray reinforcing their sense of control over tobacco.

The NRT systems with rapid delivery such as nasal spray or inhaler may have a greater potential for dependence, though there is limited data to support this as being clinically important, especially when the product is not free. Given that many decisions on NRT use are determined by the consumers themselves, with over the counter (OTC) supply, it seems that inadequate dose and duration of NRT is most common.

In general, NRT delivers 1/3-1/2 of the plasma nicotine levels achieved by smoking.

A number of (but not all) studies have found that a combination of fixed dose (patch) together with prn "active" NRT is more effective than one treatment alone. This would appear to be a good option for those who have failed on monotherapy.

NRT can and should be used for the temporary prevention and relief of withdrawal symptoms in people who have to temporarily abstain, eg inpatients or people at work. This helps maintain prescribed smoke free environments and is appropriate even for those not intending to quit yet. This is also important for the health of staff and other clients/patients.

Table 1: Nicotine Replacement Therapy Products			
Active NRT	Comments	Cost per packet*	Cost per day*
Inhaler	A cigarette like activity/ritual for the hands	\$9.00 for 6 pack \$40 per 42 refills	Approx. \$10.00
Gum	Nicotine loaded saliva can lead to gut symptoms	2 mg \$12.95 pk 30 4 mg \$15.95 pk 30	Approx \$6.00 Approx \$7.00
Lozenges		\$29.95 pk 36	Approx \$10.00
Nasal spray	New in Australia, acceptability not clear	Approx. \$20-30 (Not available at present)	
Passive NRT			
Patch	If bad dreams are a problem, remove patch overnight, otherwise change each morning.	\$27.95 per week/pk Requires 3 steps totaling 10 weeks.	\$4.00
Smoking 20-25/day	For comparison	\$9.95 PJ 30s \$8.75 Winfield 25s	\$6.60 - \$8.75

* cost may vary from different retailers and assumes typical use pattern for an ex 20-25/day smoker.
Cost updated 7-1-04.

■ Special groups

The guiding principal here is that NRT is less harmful than smoking. This applies to pregnant women, lactating women and just about anyone with cardiovascular disease. Quitting without NRT is logically preferable, however most smokers will have failed to quit in the past and we could expect NRT to improve their chances of success in the future.

Pregnancy

The WHO expert consensus of 2001 recommends allowing NRT use in pregnant smokers who have failed to quit without it (with medical involvement). There is a theoretical benefit for breast feeding mothers to use intermittent NRT such as lozenge, gum, inhaler after feeds rather than before feeds as the plasma levels may have declined by the time of the next feed. Again, overall NRT is safer than smoking.

Ischaemic Heart Disease

Don't be put off by the various product information warnings. The WHO expert consensus of 2001 recommends allowing NRT use in smokers with stable CVD who have failed to quit without it. Further, the warnings should be removed for stable CVD. For those with unstable CVD or recent (4 weeks) events, NRT should be used in consultation with the consultant. Clearly these people are at highest risk for further CVD events and have the most to gain from assisted quitting. They should be offered intensive support to quit.

There is a high degree of agreement between international and Australian expert reviews on the safety of NRT in those with known CVD.

■ A few myths debunked

- A recent prospective cohort study of 940,000 people for six years (25% smokers) found that lower tar cigarettes did not reduce the risk of dying from lung cancer (BMJ 328:10-1-04)
- Cutting down is not an effective quitting strategy
- Low tar or low nicotine cigarettes are not an effective quitting strategy

References

1. Mathers, C., Vos, T., Stevenson, C. 1999, *The Burden of Disease and Injury in Australia*. AIHW cat. No. PHE 17, AIHW, Canberra.
2. Ridolf, B. & Stevenson, C 2001, *The quantification of drug caused morbidity and mortality in Australia, 1998*. AIHW cat No PHE 29. AIHW, Canberra.
3. English, D.R., Holman, C.D.J., Milne, E.G., et al. 1995, *The quantification of drug caused mortality and morbidity in Australia*. Commonwealth Department of Human Services and Health. AGPS, Canberra.
4. Miller, M. & Wood, L. 2002, *Smoking cessation interventions. Review of evidence and implications for best practice in health care settings*, Commonwealth of Australia, Canberra.
5. Fiore, M., W. Bailey, et al. 2000, *Treating tobacco use and dependence: clinical practice guideline*, US Department of Health and Human Services, Public Health Service, Rockville.

For further reading see also a number of papers by Ivers R et al that can be found via the Pub Med web site at <http://www.ncbi.nlm.nih.gov>